

## Kentucky Department for Medicaid Services

### Drug Review Options

The following chart lists the agenda items scheduled and the options submitted for review at the May 15, 2008, meeting of the Pharmacy and Therapeutics Advisory Committee

Item	Options for Consideration
<b>Topical: Impetigo Agents</b>	<ol style="list-style-type: none"><li>1. DMS to select preferred agents based upon economic evaluation;</li><li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li></ol>
<b>Progestins for Cachexia</b>	<ol style="list-style-type: none"><li>1. DMS to select preferred agents based upon economic evaluation;</li><li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li></ol>
<b>Hepatitis B Agents</b>	<ol style="list-style-type: none"><li>1. DMS to prefer ALL current agents (Hepsera®, Baraclude®, Epivir HBV®, Tyzeka®)</li></ol>
<b>New Drugs To Market</b>	<ol style="list-style-type: none"><li>1. New drugs/line extensions that enter the market and fall within a managed class on the Preferred Drug List (PDL) or within an existing Clinical Edit will require a Prior Authorization until reviewed by the Pharmacy and Therapeutics Advisory Committee (PTAC);</li><li>2. Review will be conducted within 75 days of the market entry date (as defined by First Data Bank (FDB));</li><li>3. If a meeting is scheduled and cannot be held (i.e. due to weather issues or not achieving quorum, then the new drugs/line extensions agenda will be carried over to the next PTAC meeting;</li><li>4. New drug/line extension Prior Authorization request(s) will be reviewed for approval on a case by case basis by the State's Medical Director or designee</li></ol>
<b>Antibiotics; Oral Quinolones</b>	<ol style="list-style-type: none"><li>1. DMS to select preferred agents based upon economic evaluation;</li><li>2. Both generic ciprofloxacin and ofloxacin must be preferred (2<sup>nd</sup> generation agents);</li><li>3. Either Avelox® or Levaquin must be preferred (3<sup>rd</sup> generation agents);</li><li>4. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li></ol>

<b>Narcotics; Long-Acting</b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agents based upon economic evaluation;</li> <li>2. A topical fentanyl patch (brand or generic) must be preferred;</li> <li>3. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>
<b>Calcium Channel Blockers (DHP)</b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agents based upon economic evaluation;</li> <li>2. All current generics must be preferred;</li> <li>3. Any agent not selected as preferred will be grandfathered if there is a claim in history in the past 90 days;</li> <li>4. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>
<b>ACEI and CCB Combination</b>	<ol style="list-style-type: none"> <li>1. Rename class to: Angiotensin Modulators and CCB Combinations;</li> <li>2. DMS to select preferred agents based upon economic evaluation;</li> <li>3. DMS to select agent(s) based on economic evaluation with at least one preferred dihydropyridine and one ARB;</li> <li>4. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>
<b>Lipotropics; Non-Niacin Triglyceride Lowering Agents</b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agents based upon economic evaluation;</li> <li>2. One fibric acid derivative and at least fenofibrate must be preferred;</li> <li>3. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>
<b>Corticosteroids Intranasal</b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agents based upon economic evaluation;</li> <li>2. At least one agent with pediatric indications must be preferred;</li> <li>3. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>
<b>Alzheimer's Agents; Cholinesterase Inhibitors</b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agents based upon economic evaluation;</li> <li>2. Cognex® cannot be the sole preferred agent (if selected as preferred);</li> <li>3. DMS to allow continuation of therapy if a claim in history in the past 90 days;</li> <li>4. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>
<b>Beta-Agonist Inhalers; Combination Products</b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agents based upon economic evaluation;</li> <li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>

<b>High Potency Statins</b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agents based upon economic evaluation;</li> <li>2. Vytorin® cannot be the sole preferred agent (if selected as preferred);</li> <li>3. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>
<b>Beta-Agonist; Long Acting Agents</b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agents based upon economic evaluation;</li> <li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>
<b>Proton Pump Inhibitors</b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agents based upon economic evaluation;</li> <li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>
<b>Alpha/Beta Blockers (Oral)</b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agents based upon economic evaluation;</li> <li>2. All current generic agents must be preferred;</li> <li>3. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>
<b>Ophthalmic Prostaglandin Inhibitors</b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agents based upon economic evaluation;</li> <li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>
<b>Ophthalmic Antihistamines</b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agents based upon economic evaluation;</li> <li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>
<b>Antibiotics; Macrolides</b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agents based upon economic evaluation;</li> <li>2. Generic clarithromycin and azithromycin and all current generic erythromycin(s) must be preferred;</li> <li>3. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>
<b>New Agent(s) Review*</b>	<ol style="list-style-type: none"> <li>1. DMS to assign preferred/non-preferred status to these agents based upon economic evaluation;</li> <li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization</li> </ol>

\*Simcor®, Pristiq®, Renvela®, Bystolic®, Lamisil Granules®, Omnaris AQ®, Fenoglide®, Sular® (reformulated), Treximet®, Luvox CR®, Patanase® as listed on the May 15, 2008 PTAC Agenda